

## BUPRENORPHINE – SUBOXONE AUTHORIZATION

### AGENCY SECTION

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA)  
CERTIFIED CHEMICAL DEPENDENCY TREATMENT AGENCY

AGENCY NUMBER (USE NUMBER IN GREENBOOK  
DIRECTORY OF CERTIFIED SERVICES IN WASHINGTON)

The certified chemical dependency treatment agency listed above verifies that the patient listed below is sixteen years of age or older; alcohol or opiate dependent, with opiate dependency as the primary addiction; and has been admitted to publicly funded chemical dependency treatment. The patient's Chemical Dependency Professional (CDP) hereby recommends the use of Buprenorphine as a part of the patient's treatment plan as indicated by signature below.

CDP'S SIGNATURE

DATE

CDP'S PRINTED NAME

CDP'S TELEPHONE NUMBER

### PATIENT SECTION

PATIENT'S NAME

PATIENT'S MAA PIC NUMBER

DATE ADMITTED TO CHEMICAL DEPENDENCY  
TREATMENT

☐ Opiate Dependent

### PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_ (print patient's name) authorize the certified chemical dependency treatment agency indicated above to disclose patient identifying information, my status as a patient, and their treatment recommendation to my physician and the pharmacy indicated below for obtaining a prescription for Buprenorphine.

PRINT PHYSICIAN'S NAME

PRINT PHARMACY'S NAME

I understand that my alcohol and/or drug treatment records are protected under Federal and State Confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations, Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 Code of Federal Regulations, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **either 90 days from the date signed, or the following specific date, event, or condition upon which this consent expires:**

\_\_\_\_\_. I understand that generally \_\_\_\_\_  
(insert name of certified chemical dependency agency) may not condition my treatment on whether or not I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

PATIENT'S SIGNATURE

DATE

SIGNATURE OF PARENT, GUARDIAN, OR  
AUTHORIZED REPRESENTATIVE (WHEN REQUIRED)

DATE

### PHYSICIAN SECTION

PHYSICIAN'S NAME

TELEPHONE NUMBER

MEDICAID PROVIDER NUMBER OR DEA ID NUMBER

ADDRESS

Date ordered by physician:

Proposed treatment start date:

### PHARMACY SECTION

PHARMACY'S NAME

MEDICAID PROVIDER NUMBER

I have received a prescription for Buprenorphine for the patient named above from the patient's physician and have filled the prescription as authorized. I understand that reimbursement for the Medical Assistance Administration (MAA) for Buprenorphine shall only be made under the following conditions.

1. The medication is provided as part of a comprehensive treatment program as verified by the certification provided above.
2. Payment for the medication is limited to six months of continuous use. The medication is limited to a fourteen-day (14-day) supply on each fill.
3. The pharmacy shall include the prescribing physician's MAA Medical Provider number on the MAA billing form.
4. Record of this certification shall be kept on file at the pharmacy for MAA audit purposes. Prescriptions reimbursed by the MAA for Buprenorphine without this certification record on file shall be considered an overpayment.

PHARMACIST'S SIGNATURE

DATE

TELEPHONE NUMBER

ADDRESS

## **BUPRENORPHINE – SUBOXONE AUTHORIZATION FORM INSTRUCTIONS**

If a patient and “qualified physician” agree that Buprenorphine may be an appropriate chemical dependency treatment and wish to seek payment for a prescription for the medication, to be made by the state, a Buprenorphine Authorization form must be completed.

1. Complete the **PHYSICIAN SECTION**:

?? Enter the name of the physician and the physician’s Medicaid Provider number or their DEA identification number that specifically authorizes office-based treatment.

?? Enter the date the physician determined the patient was in need of Buprenorphine treatment and the proposed treatment start date.

2. Complete the **AGENCY SECTION**:

?? Enter the name of the certified chemical dependency treatment agency and the agency’s 8-digit certification agency identification number found in the Directory of Certified Chemical Dependency Treatment Services in Washington State (commonly known as the Greenbook) published by the Division of Alcohol and Substance Abuse.

?? The patient’s chemical dependency professional signs and dates the form at the end of this section.

3. Complete the **PATIENT SECTION**:

?? Enter the patient’s name.

?? Enter the patient’s Medical Assistance Administration Patient Identification Code (PIC) number.

?? Enter the date the patient was admitted to Buprenorphine treatment

?? A DSM-IV-TR diagnosis for opiate dependency (heroin or other short-acting opioids).

Complete the **Patient Authorization for Disclosure of Confidential Information SECTION**, being sure to discuss this disclosure with the patient and by having him/her sign and date the disclosure statement section.

4. Give the patient copies of the Buprenorphine Authorization form to take to his/her physician, primary Chemical Dependency Professional (CDP), and then to the pharmacy to obtain the prescription.

?? The physician should keep a copy of the Buprenorphine Authorization Form for the medical record.

?? The CDP at the chemical dependency treatment agency should keep a copy for the patient’s record.

5. The Pharmacist will complete the **PHARMACY SECTION**: The Pharmacist keeps the final copy on file at the pharmacy for future Medical Assistance Administration audit purposes.

6. The physician, the patient, the CDP at the chemical dependency treatment agency, and the Pharmacist should all keep copies of the Buprenorphine Authorization form.